Almazan (c)

MEDICAL CONSULTANTS
www.mrkmedconsultants.com

January 19, 2006

Jenny Li
Low, Ball & Lynch
505 Montgomery Street, 7th Floor
San Francisco, CA 94111-2584

MEDICAL EVALUATION

RE:	**Esther GALVEZ/ALMAZAN** v. Amtrak, et al.
Case #:	U.S. District Court Case # CIV-S-04-1872 MCE/PAN
DOI:	04/17/04
DOE:	01/12/06
POE:	CARMICHAEL, CA
MRK#:	6152

Dear Ms. Li:

Per your request and authorization, a Medical Evaluation was performed on Esther Galvez at the Carmichael Office of MRK Medical Consultants.

Ms. Galvez is represented by Mr. Martin Jaspovice, who was not present at the evaluation. No recording devices were utilized. My face-to-face interview and examination began at 4:00 p.m. and concluded at 4:20 p.m. Ms. Galvez's daughter, Lorie Almazan, was evaluated just prior to Ms. Galvez's evaluation. Ms. Galvez and Ms. Almazan were both present in the room during the interview and examinations.

HISTORY:
Ms. Galvez stated that on 04/17/04, she was the restrained front seat passenger in a Mitsubishi SUV when the vehicle was broadsided on the driver's side by a van. They did not know the estimated speed of the vehicle that hit them, however the Mitsubishi was totalled. The airbags deployed. Ms. Galvez stated that the airbag slammed into her face and caused the glasses she was wearing to be pushed into her face, although it was unclear whether or not the lenses broke. She stated that she felt pressure from her seatbelt on her chest. Ms. Galvez stated that immediately after the accident she had chest pain and difficulty breathing. She does not believe she experienced loss of consciousness, but may have been "out of it" for

a few seconds. She remembers her daughter and son screaming and emergency personnel arriving at the scene.

Ms. Galvez was transported by ambulance to Dameron Hospital where she was evaluated and found to have a fracture of her sternum, neck sprain and multiple contusions. She was admitted to the hospital for care. She underwent an echocardiogram to determine whether or not there was any cardiac contusion. The echocardiogram was normal. Ms. Galvez was discharged from the hospital on 04/19/04.

Further follow-up was obtained with Dr. Virender Kamboj, M.D. and Gilbert Greene, D.O. Ms. Galvez had a follow-up echocardiogram on 04/29/04, which was normal. She underwent osteopathic manual therapy of her neck by Dr. Greene on a few occasions. She has not had any specific treatment for her neck or back for at least one year. There are no plans for her to obtain any further studies or treatment for any injuries sustained on 04/17/04.

PAST MEDICAL HISTORY:
Ms. Galvez denied any prior injuries, problems or treatment with her neck, back or right shoulder.

WORK HISTORY:
At the time of the subject accident, Ms. Galvez was retired.

CURRENT MEDICATIONS:
Aspirin on occasion.

CURRENT SUPPORT DEVICES:
None.

PERSONAL ACTIVITY LIMITATIONS:
Ms. Galvez stated that she is able to walk for 40 minutes, however she does not walk as often as she used to. She stated that prior to the subject accident she walked every day and now only walks approximately three days per week. She stated that she cannot rake her leaves for a very long period of time. Ms. Galvez stated that she is afraid to go in her car or ride a bus.

CURRENT SYMPTOMS:
Upper Back: Ms. Galvez stated that she has a deep pain in the right side of her neck continuous with the right side of her upper back going to the right scapular area. The major focus of the pain is in the mid point of the trapezius just above the superior medial border of the scapula. The pain does not radiate into her arm or into the low back. The symptoms are made worse by strenuous physical activity such as raking leaves. The symptoms are usually helped by stretching and resting. There is no pain in that area during the night. She has noticed some clicking in her neck when she turns, although it does not cause much pain. Ms. Galvez denied numbness or tingling in either her arms or legs. She has not lost any particular strength or motion in her upper extremities.

Chest: Ms. Galvez stated that she has an occasional sharp pain in the sternal area. She could not identify any particular activity or event that causes the pain to occur, however it usually goes away quickly.

Headaches: Although Ms. Galvez did not relate that she continued to have any symptoms of headaches to me, she did note ongoing intermittent headaches at the time of her deposition testimony in October 2005.

PHYSICAL EXAMINATION:
Ms. Galvez presented as a fairly healthy 76-year-old female who appeared comfortable. She is 5 feet, 2 inches in height and weighs 127 pounds. She moved easily about the office and exam room.

Her cervical spine had a 30-40% loss of range of motion, although that may have been normal considering her age. The loss of motion was primarily in rotation and bending. She complained of some clicking during motion, but no actual pain. With palpation Ms. Galvez reported pain with deep pressure of the trapezius and the upper part of the sternocleidomastoid muscle on the right side only. There was no reported pain with palpation around the scapulae, shoulders or thoracic spine.

Shoulder range of motion was normal without reported pain. She had normal sensation in all fingers. Ms. Galvez demonstrated normal grip strength and normal extension strength of her fingers and wrists.

The thoracic spine had slight increased kyphosis consistent with her age; however there was no scoliosis or other abnormality.

DIAGNOSTIC STUDIES:
I was not provided with any diagnostic studies for review. The medical records make reference to the following x-ray reports:

04/18/04	CT scan of the chest. Impression: Fracture of the sternum with associated soft tissue hematoma. Calcified pleural plaque formation within both hemithoraces. Gallstones within the gallbladder.
04/18/04	X-ray of the cervical spine. Impression: Mild degenerative changes.
04/18/04	X-ray of the cervical spine with flexion and extension views. Impression: Alignment remains anatomic in flexion and extension.
04/18/04	X-ray of the thoracic spine. Impression: Mild degenerative changes.
04/19/05	Echocardiogram. Impression: Mild generalized left ventricle hypokinesis.
04/29/04	Echocardiogram. Impression: Normal.

MEDICAL RECORD REVIEW:
I was provided with medical records encompassing a time period from 01/11/01 through 03/10/05. I was also provided with the deposition testimony of Esther Galvez dated 10/18/05. **These records have been collated and placed in chronological order by technical staff. Though all entries are read, non-pertinent entries (e.g. common cold, etc.) may not receive comment. Illegible and/or non-dated material may not be commented upon.** These records have been reviewed in detail. A summary of pertinent records is attached as an addendum to the report.

DIAGNOSES:
1. **Sternal fracture, sustained 04/17/04.**

2. **Cervical sprain/strain, sustained 04/17/04.**

DISCUSSION:
Ms. Galvez was involved in a motor vehicle accident on 04/17/04, in which she suffered a fracture of the sternum due to either the affect of the seatbelt restraint or possibly the airbag or a combination thereof. Her sternal fracture did not require any specific treatment and went on to heal with minimal residual symptoms. No further treatment will be necessary for this injury. It is likely that any residual symptoms will continue to decrease over time.

Ms. Galvez also suffered a contusion to her face and other areas, however those resolved fairly quickly subsequent to the subject accident.

She also suffered a soft tissue injury to the cervical spine. She does have underlying degenerative changes of the cervical and thoracic spine which may contribute to her ongoing symptoms. Her reported symptoms appear to be more muscular and located in the trapezius muscle. Although Ms. Galvez stated that she continues to experience symptoms in the right trapezius area, the records from her primary care physician note that she often had no pain or that she had occasional pain.

It is my opinion that Ms. Galvez's symptoms will continue to improve and she will not require any further treatment for her ongoing symptoms. It appears that Ms. Galvez has very slight disability as a result of her ongoing complaints. That disability is manifested only when she does strenuous work such as raking leaves.

Although Ms. Galvez reported ongoing intermittent headaches in her deposition, she has not reported those symptoms to her healthcare providers nor did she report them to me at the time of my evaluation. It is very unlikely that she will require any further treatment for ongoing headaches since she has not felt them significant enough to report them to her healthcare providers.

Prior to any deposition, arbitration or trial testimony, I would appreciate the opportunity to review the diagnostic studies, as well as any additional pertinent medical records not reviewed for this report.

I reserve the right to change any opinions expressed upon production of additional medical records or diagnostic studies. Questions should be directed to my attention.

DECLARATION:
I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and believe, except as to information I have received from others. As to that information, I declare that it accurately describes the information provided to me and, except as noted herein, I believe it to be true. The opinions and conclusions expressed in this report are my own. No one else participated in the examination or preparation of this report. All conclusions reached and opinions expressed are based on the premise that the information is properly admissible evidence and has been properly obtained in accordance with the laws of the State of California and/or the jurisdiction where the legal action has been filed.

Executed on **January 19, 2006** in the County of Sacramento.

RESPECTFULLY,

EDWARD W. YOUNGER, III, M.D.
Orthopedic Consultant

EWY:lm

MEDICAL RECORD REVIEW OF ESTHER GALVEZ

The following is a chronological summary of the review of the medical records of Esther Galvez. Records received for review were dated from 1/11/01 through 3/10/05. The following summary may contain spelling, typographical and/or grammatical errors.

3/22/04 Virender Kamboj, MD. (All notes handwritten and relatively illegible). Husband recently died. FBS 125. Lungs clear, no shortness of breath. Dx: diabetes mellitus.

DATE OF INCIDENT: 4/17/04

4/17/04 American Medical Response. Prehospital care report: was a restrained front seat passenger in an MVA, vehicle had moderate front end damage, air bags deployed. C/o back and chest pain. Transferred to Dameron Hospital.

4/17/04 Dameron Hospital. Emergency room report: in MVA, c/o chest and neck. Pain in her chest and upper back. Dx: contusion of chest wall, chest and back secondary to MVA. Plan: admit.

4/17/04 X-ray of the chest requested by Alan Genicoff, MD. Impression: no acute infiltrates.

4/18/04 CT scan of the chest requested by Emergency room. Preliminary impression: probable fracture of the sternum, tiny amount of hematoma adjacent to the sternum.

4/18/04 Dameron Hospital. Sanjeev Sharma, MD. History and physical: belted passenger involved in rear end collision. No loss of consciousness. C/o neck and chest pain. CT scan reveals a sternal fracture. Plan: 2-dimensional echocardiogram to r/o cardiac contrusion, cervical and thoracic spine films.

4/18/04 X-ray of the cervical spine requested by Dr. Sharma. Impression: mild degenerative changes.

4/18/04 X-ray of the cervical spine with flexion and extension requested by Dr. Sharma. Impression: alignment remains anatomical in flexion and extension.

4/18/04 X-ray of the thoracic spine requested by Dr. Sharma. Impression: mild degenerative changes.

4/18/04 CT scan of the chest #5 requested by Dr. Genicoff. Impression: fracture of the sternum with associated soft tissue hematoma, calcified pleural plaque formation within both hemithoraces, gallstones within the gallbladder.

4/19/04 Dameron Hospital. Dr. Sharma. Discharge summary: admitted on 4/18/04 after being involved in a rear end MVA. Was a belted passenger with no loss of consciousness. C/o neck and chest pain. Dx: s/p MVA, sternal fracture, multiple contusions, diabetes mellitus. Plan: discharge home.

4/19/04 Echocardiogram. Impression: mild generalized left ventricular hypokinesis.

RE: Galvez, Esther

4/27/04	Dr. Kamboj. Had MVA one week ago and in hospital. Has ecchymosis on legs. Dx: MVA.
4/29/04	Dr. Kamboj. Has hypertension, DM and chest pressure after accident. Has risk factors for heart problems. Plan: r/o pericardial effusion.
4/29/04	Echocardiogram. Impression: normal.
5/5/04	Office of Gilbert Greene, DO. Patient completed a health questionnaire.
5/5/04	Dr. Greene. (All notes are handwritten and relatively illegible). C/o upper back and neck pain from MVA on 4/18/04. Suffered a fractured sternum; in hospital one night. Dx: fracture sternum, cervical strain, thoracic strain. Plan: OMT C-spine, thoracic spine and sternum.
5/18/04	Dr. Kamboj. Reports feeling fine, no chest pain, no shortness of breath.
5/19/04	Dr. Greene. F/u on fractured sternum. Was seen on 5/5/04 and treated with OMT. Pain resolved after. Is pain free and feels well today. Dx: s/p fracture of the sternum, diabetes mellitus.
7/19/04	Dr. Kamboj. Echocardiogram was within normal limits. Feels fine.
10/12/04	Dr. Greene. C/o upper back and shoulder pain. Dx: diabetes mellitus, ___right shoulder and thoracic. Plan: OMT thoracic spine and right shoulder.
11/18/04	Dr. Greene. Back and chest pain treated on 10/12/04, feels better. No pain.
3/10/05	Office of Dr. Greene. Feels well other than occasional back pain.
10/18/05	Deposition of Esther Galvez.

Edward Younger

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RE:	**Lorie ALMAZAN/GALVEZ** v. Amtrak, et al.
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DOI:	04/17/04
DOE:	01/12/06
POE:	CARMICHAEL, CA
MRK#:	6153

Dear Ms. Li:

Per your request and authorization, a Medical Evaluation was performed on Lorie Almazan at the Carmichael Office of MRK Medical Consultants.

Ms. Almazan is represented by Mr. Martin Jaspovice, who was not present at the evaluation. Ms. Almazan was accompanied to the evaluation by her mother, who was also involved in the same accident and was examined on 01/12/06. My face-to-face interview and examination began at 3:35 p.m. as Ms. Almazan was late for her scheduled appointment at 3:00 p.m. and concluded at 4:00 p.m.

HISTORY:
Ms. Almazan stated that on 04/17/04, she was the rear, right side passenger in a Mitsubishi SUV that was hit by another vehicle on the driver's side. She stated that at the time of the collision, she felt her left knee hit something. She also hit her head on something, however she did not experience loss of consciousness. Ms. Almazan was able to exit the vehicle under her own power and was concerned about her mother who was sitting directly in front of her. Ms. Almazan was able to open her mother's door and assisted her with deflating the airbag and checking on her condition.

Ms. Almazan stated that soon after the subject accident, she felt pain in her knee and felt unstable. She was transported by ambulance to Dameron Hospital where she was evaluated. X-rays of her knee were obtained and she was released home with instructions to follow-up with her primary care physician. Ms. Almazan was diagnosed with head contusion and left leg contusion.

Ms. Almazan was seen by Gilbert Greene, D.O. two days after the subject accident and was treated for head contusion, cervical strain and left knee contusion. She received osteopathic manual therapy and was given a prescription for Vicodin and Motrin. One month later, Ms. Almazan continued to complain of pain and a MRI scan of the left knee was obtained. After receiving the results of the MRI scan, Dr. Green referred Ms. Almazan to Kevin Mikaelian, M.D., an orthopedic surgeon, who diagnosed a tear of the posterior cruciate ligament. Dr. Mikaelian recommended physical therapy. It does not appear that Ms. Almazan started physical therapy until 09/22/04, which was completed on 12/02/04, at which time she was discharged to a home exercise program.

Ms. Almazan had a second opinion by Gary Murata, M.D., an orthopedic surgeon, in September 2004. Dr. Murata agreed with the diagnosis of posterior cruciate injury and noted that she had a poorly rehabilitated knee and recommended further physical therapy. Dr. Murata did not think that Ms. Almazan was a candidate for reconstructive surgery at that time. It appears that Ms. Almazan's last visit with Dr. Murata was on 12/15/04, at which time he recommended that she continue her home exercise program. Ms. Almazan had further follow-up with Dr. Greene and continued to complain of pain in her left knee.

In September 2005, Ms. Almazan complained of low back pain.

Ms. Almazan stated that her knee has not improved significantly over the last few months. There are no further scheduled treatments or diagnostic studies.

PAST MEDICAL HISTORY:
Ms. Almazan denied any prior injuries or problems with her left knee.

WORK HISTORY:
At the time of the subject accident, Ms. Almazan was employed as a jeweler. This job required her to be on her feet all day. She stated that because of her knee injury she was not able to return to that position. She remained off work for over one year and then was able to find other work which was a sedentary position.

CURRENT MEDICATIONS:
One-half of a Vicodin tablet approximately five times a month. Advil on occasion.

CURRENT SUPPORT DEVICES:
Ms. Almazan stated that she tried using an off-the-shelf elastic brace, however it did not give her much benefit and therefore she discontinued it.

PERSONAL ACTIVITY LIMITATIONS:
Ms. Almazan stated that she is unable to run. She previously enjoyed running three days per week. She stated that she is unable to stand on her feet for long periods of time. Ms. Almazan stated that she has pain if she sits with her left knee bent under her for any length of time. She stated that she is unable to wear high heels.

CURRENT SYMPTOMS:
Left Knee: Ms. Almazan stated that she has intermittent left knee pain that is poorly localized. She stated that it is sometimes on the anterior medial side of the left knee and sometimes in the back of the knee radiating into her calf. She stated that she also has a sensation that her left knee does not feel strong. She stated that she feels stiffness in her knee and has not been able to straighten it or bend it as much as previously. Ms. Almazan stated that her symptoms are aggravated by prolonged standing or walking. She is unable to bend, squat or put any pressure on her left knee, such as when kneeling. Ms. Almazan stated that the left knee symptoms are improved by resting and avoiding activities that aggravate it. She stated that when she has left knee pain she uses ice, which is usually every day. She stated that at night she will have left knee pain if she has been too active during the day. She has not had any numbness or tingling in her leg. There has been no pain radiating into her left foot.

Left Hip: Ms. Almazan stated that she has occasional pain in the posterior aspect of her left hip, which she ascribed to a back problem.

PHYSICAL EXAMINATION:
Ms. Almazan presented as a healthy, moderately overweight 40-year-old female. She is 5 feet, 3 inches in height and weighs 167 pounds. She appeared comfortable when sitting through the exam.

Her gait demonstrated an obvious limp with favoring of her left leg. She also did not fully extend her knee during the toe-off phase of gait.

The appearance of the left knee was normal. I could not appreciate any swelling or deformity of the left knee. There was no effusion palpable. Her range of motion was limited because of her guarding. Ms. Almazan would not allow extension for the last ten degrees. She would flex only to 110°. The right knee had normal range of motion with full extension to 140° of flexion. Ms. Almazan reported pain with palpation along the medial joint line, however it was fairly diffuse. Her patella tracked well and there was no palpable crepitation with active knee extension. She appeared to have only fair strength in her quadriceps, possibly due to poor effort or guarding. There was no pain reported with compression of the patella. Her ligament exam revealed normal stability of the collateral and anterior cruciate ligaments. Her posterior cruciate ligament was lax with a posterior drawer and a posterior sag test.

Distally, she had normal muscle strength in all muscle groups. She had good motion of her ankle and foot.

Both hips had normal range of motion without reported pain.

DIAGNOSTIC STUDIES:
I was provided with the following diagnostic studies for review:

05/24/04 MRI study of the left knee. There is a tear of the posterior cruciate ligament and a mild bone contusion involving the anterior portion of the lateral tibial plateau.

The medical records reference the following diagnostic studies:

04/17/04 X-rays of the left knee. Impression: No fracture.

MEDICAL RECORD REVIEW:
I was provided with medical records encompassing a time period from 04/17/04 through 09/27/05. I was also provided with the deposition testimony of Lorie Almazan dated 10/18/05. **These records have been collated and placed in chronological order by technical staff. Though all entries are read, non-pertinent entries (e.g. common cold, etc.) may not receive comment. Illegible and/or non-dated material may not be commented upon.** These records have been reviewed in detail. A summary of pertinent records is attached as an addendum to the report.

DIAGNOSIS:

Left knee posterior cruciate ligament tear, sustained 04/17/04.

DISCUSSION:
Ms. Almazan was involved in a motor vehicle accident in which she was the rear seat passenger. Based on her history, it appears that she was thrown forward striking her left leg on either the console or the back of the seat. She complained of immediate pain and was found to have a contusion over the left knee. This mechanism of injury is consistent with one that would cause a tear of the posterior cruciate ligament. The impact on the proximal tibia pushes the tibia backwards stretching or tearing the ligament. Once the posterior cruciate ligament (PCL) is torn, it usually does not heal on its own. The majority of patients with a PCL tear are able to return to most usual activities without difficulty. It is unclear why Ms. Almazan continues to experience significant pain and reported disability. It is possible that due to the instability, she has increased stress on the patellofemoral joint.

Ms. Almazan's current residual symptoms and disability are in part due to inadequate rehabilitation of her knee. It does not appear that Ms. Almazan started physical therapy in a timely manner nor was she consistent with attendance at physical therapy. It is unclear whether or not she has been consistently doing her home exercise program. There is no physiologic reason that she would not be able to restore full range of motion to her left knee. If Ms. Almazan were to work on strengthening of the quadriceps and hamstring muscles, she would probably have a much better outcome.

Due to Ms. Almazan's subjective complaints, she is not able to work in a job which requires prolonged standing. She has been able to work in a sedentary position without apparent difficulty.

It is my opinion that Ms. Almazan is not a candidate for reconstructive surgery of the PCL. It is very unusual to require this type of surgery since the majority of patients are able to function fairly normally despite having posterior instability. The laxity of the PCL would prevent Ms. Almazan from doing more strenuous activities such as sports and possibly even running for exercise. There would be no problem with cycling or using other types of exercise machines.

I reserve the right to change any opinions expressed upon production of additional medical records or diagnostic studies. Questions should be directed to my attention.

DECLARATION:
I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and believe, except as to information I have received from others. As to that information, I declare that it accurately describes the information provided to me and, except as noted herein, I believe it to be true. The opinions and conclusions expressed in this report are my own. No one else participated in the examination or preparation of this report. All conclusions reached and opinions expressed are based on the premise that the information is properly admissible evidence and has been properly obtained in accordance with the laws of the State of California and/or the jurisdiction where the legal action has been filed.

Executed on **January 19, 2006** in the County of Sacramento.

RESPECTFULLY,

Edward Younger

EDWARD W. YOUNGER, III, M.D.
Orthopedic Consultant

EWY:lm

MEDICAL RECORD REVIEW OF LORIE ALMAZAN

The following is a chronological summary of the review of the medical records of Lorie Almazan. Records received for review were dated from 4/17/04 through 9/27/05. The following summary may contain spelling, typographical and/or grammatical errors.

DATE OF INCIDENT: 4/17/04

4/17/04 Dameron Hospital. Emergency room report: was restrained passenger in the back of a vehicle during an MVA. C/o head, back, chest, and left knee. She was found walking at the scene. Dx: MVA, head contusion, left leg contusion. Plan: Naprosyn

4/17/04 X-ray of the left knee requested by Bolanle Akinlade, MD. Impression: no fracture.

4/19/04 Office of Gilbert Greene, DO. Patient completed a health questionnaire.

4/19/04 Dr. Greene. (All notes are handwritten and not all are legible). C/o head, neck and left knee pain. In MVA. Dx: head injury/contusion, cervical strain, left knee sprain/contusion. Plan: OMT, Vicodin, Motrin, off work for one week.

4/26/04 Dr. Greene. Continued left knee pain. Dx: acute sprain left knee. Plan: OMT left knee.

5/5/04 Dr. Greene. C/o left knee pain secondary to MVA. Dx: sprain left knee. Plan: OMT, continue meds.

5/19/04 Dr. Greene. C/o continued left knee pain. Dx: left knee strain. Plan: OMT left knee, MRI of knee.

5/24/04 MRI of the left knee requested by Dr. Greene. Impression: tear of the posterior cruciate ligament, bone contusion involving the anterior portion of the lateral tibial plateau.

6/7/04 Dr. Greene. C/o continual pain in left knee since MVA in April. Dx: torn posterior cruciate ligament and contusion anterior left tibial plateau. Plan: Ibuprofen, Vicodin, crutches, refer to orthopedic for evaluation.

6/28/04 Kevin Mikaelian, MD. Orthopedic consultation: injured left knee on 4/17/04 when she was hit by a bus. She is having persistent soreness with weightbearing and with sitting for long periods of time. Dx: PCL tear. Plan: physical therapy.

7/12/04 Dr. Greene. c/o pain in left knee. Was seen by ortho and was sent to physical therapy. Dx: torn left posterior cruciate ligament. Plan: OMT left knee, Vicodin, Naprosyn, continue physical therapy.

8/5/04 Dr. Greene. Crying and frequently reliving the accident. Pain in left knee is better Still refusing some pain medications. Psychologically emotionally labile. Dx: depression, PTSS, torn left posterior cruciate ligament. Plan: continue meds, refer to Dr. O'Brien.

8/15/04 Floyd O'Brien, PhD. Evaluation: met with her on 8/10/04. Described a symptom complex indicating posttraumatic stress disorder. She will try to arrange treatment with me.

9/9/04 Dr. Greene. F/u on pain in left leg. Dx: left knee pain, torn left PCL, post traumatic stress syndrome. Plan: OMT left knee, Vicodin, Ibuprofen, left knee exercises.

9/13/04 Office of Gary Murata, MD. Patient completed a questionnaire on which she states that she has torn ligaments in her left knee and she is unable to walk properly or function and is in extreme amounts of pain.

9/14/04 Dr. Murata. C/o left knee pain, stiffness and weakness. Was injured in an MVA on 4/17/04. Was in back seat and her knee struck the center console. Noted immediate pain and swelling. Since this time she has been unable to work, has difficulty walking normally, has weakness with giving way. Had one physical therapy session three months ago which made her knee worse. Has been taking Vicodin and Ibuprofen. She has depression. Dx: posterior cruciate injury; poorly rehabilitated knee. Plan: physical therapy. It is doubtful she has enough instability to consider posterior cruciate reconstruction.

9/22/04 Matrix Rehabilitation/Advanced Physical Therapy (Matrix Rehab). The patient completed a questionnaire.

9/22/04 Matrix Rehab. Physical therapy evaluation: left knee beginning on 4/17/04 secondary to MVA. No prior history of knee dysfunction. Previously ran three times a week. Assessment: dashboard type injury with resultant left knee instability and pain. Plan: two times per week for six weeks.

9/22/04 Matrix Rehab. There are treatment notes dated from 9/22/04 through 12/2/04.

10/5/04 Dr. Greene. C/o pain in left knee. Is in physical therapy. Also has PTSS and is seeing Dr. O'Brien. Her bad dreams are better. Dx: left knee pain, torn PCL, anxiety. Plan: Celebrex, Vicodin, continue physical therapy.

10/8/04 Matrix Rehab. Discharge summary: last seen on 9/28/04. She reported increased swelling. She completed two of twelve visits prescribed. Did not return. Recommend discharge to home program.

11/1/04 Dr. Murata. Continues to have knee pain intermittently. Today has significant pain and stiffness; has trouble walking; has an antalgic gait pattern. Has had some improvement with therapy. Dx: posterior cruciate injury. Plan: could be a candidate for arthroscopic surgery, but continue therapy two times a week for the next four weeks.

11/22/04 Dr. Greene. C/o left knee pain since MVA. Being treated with physical therapy. Pain increased last night. Celebrex ordered but not taking it as she was worried about drug side effects. Dx: PCL tear by MRI of 5/24/04. Plan: Vicodin, Celebrex, wear knee brace, continue physical therapy, refer for second opinion.

12/2/04 Matrix Rehab. There are treatment notes dated from 9/22/04 through 12/2/04. Last note states that she has occasional periods of no pain, increased pain with excessive weight bearing activities. Continued medication reliance. Has continue difficulty with stairs.

12/2/04 Matrix Rehab. Progress report: occasional pain, increasing to severe pain with excessive walking. Is compliant with home exercise program. Gait normalizing. Difficulty with up and down stairs. Plan: discharge to home exercise program.

12/15/04 Dr. Murata. Felt some improvement of her knee; still has considerable weakness. Has completed therapy but therapist has not noted much improvement of her pain level. Dx: posterior cruciate injury. Plan: patient will try to rehab knee herself at a health club. Disability extended to 3/1/05.

1/31/05 Dr. Greene. Has chronic pain, has completed physical therapy with some benefit. Experiencing daily pain with ambulation and daily activity. Wants to return to work but is worried about tolerance. Dx: posterior cruciate tear, left knee, chronic pain. Plan: continue Celebrex, Vicodin and Prilosec.

2/14/05 Dr. Greene. C/o pain in the left knee radiating to left leg. Dx: left knee pain, torn posterior cruciate ligament left knee. Plan: OMT knee and left leg, rest.

3/31/05 Dr. Greene. Continuing pain in left knee but is better and is walking better, is exercising. Dx: left knee pain, torn cruciate ligament. Plan: refill Celebrex, Vicodin.

4/18/05 Dr. Greene. C/o pain in left knee. Is improving but continues to have pain. Dx: left knee pain, torn posterior cruciate ligament. Plan: continue meds, disability form filled out.

7/7/05 Dr. Greene. C/o pain in left knee. No new trauma. Has history of torn left posterior cruciate ligament. Was doing well but knee suddenly became swollen and painful. Dx: s/p left posterior cruciate ligament tear, left knee pain, strain left knee. Plan: Naprosyn, Darvocet, rest.

9/27/05 Dr. Greene. C/o low back pain radiating to lower abdomen and down legs. Has chronic knee pain secondary to MVA. Requesting DMV disability placard. Dx: chronic left knee pain secondary to poor rehabilitation of posterior cruciate tear, back and abdominal pain. Plan: Celebrex, Vicodin, DMV placard denied, discontinue Naprosyn.

10/18/05 Deposition of Lorie Almazan.

Edward Younger

EDWARD W. YOUNGER, III, M.D.
Orthopedic Consultant